

## INDEX OF SURGICAL PROGRESS.

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### GENERAL SURGERY.

**I. Some New Cases of Actinomycosis in Man.** By DR. PARTSCH (Breslau). The author publishes eight new cases of actinomycosis occurring in man, three of which were operated upon by Professor Fischer, of Breslau, and compares certain points in the clinical histories with our present knowledge of the disease as established by the works of Ponfick, Israel and others.

Four cases are given where the disease was localized in the lower jaw or neck, one in which actinomycosis appeared in the cicatrix after operative removal of the breast for carcinoma, and three where the abdominal cavity was invaded by the fungus.

The main features of the cases are as follows:

I. Healthy man, had had three roots of decayed teeth extracted, in order to relieve inflammatory swelling on cheek, without effect. Tumor hard, little painful, not movable against the bone. Mouth can be only slightly opened. Warm formentations produce fluctuation after two days, when incision vents reddish-grey granulation-masses containing yellow specks, which prove to be actinomyces germs. Iodoform. Recovery in two weeks.

II. Man, æt. 36. One year previously toothache; left molars fell out; presented a small tumor connected with the parotid fascia, scarcely painful, hard to the touch. Taken for lymphatic abscess and incised when typical actinomycosis fungus was found. Wound curetted; primary union.

III. Man, æt. 25. April, 1883, difficulty of swallowing, without fever; swelling at angle of lower jaw; poultices; suppuration; burrowing of abscess along sterno-cleido-mastoid muscle; perforation of skin near sternum. Fistula laid open, and actinomycosis found as diagnosed, July, 1883. Antiseptic dressing. Recovery.

IV. Woman, æt. 35. November, 1884, toothache in lower molar, with acute swelling, after which a small tumor remained. June, 1885, suppuration of tumor; burrowing of pus; perforation near hyoid bone; fistula established. Diagnosis made from discharge. Extirpation, antiseptic dressings. Erysipelas of wound. Subsequent recovery. In one of the extracted roots actinomyces-growth was found.

V. Man, æt. 60. Operated for carcinomatous tumor of left breast. Large cavity remained after extirpation of axillary glands, and removal of much integument over tumor. Transplantation of skin grafts during granulation. A fistula finally persisted, which was closed by means of iodoform bougies. Two months later small abscesses formed in the cicatrix, which contained actinomyces. Curetting of no avail. Deep incision revealed focus at axillary margin of major pectoral muscle, enclosed in cicatricial tissue. Excision and application of actual cautery. Recovery.

VI. Man, æt. 32. Three weeks before admission, pain on micturition. One week subsequently, swelling in right inguinal region, becoming painful. Alvar obstruction.

On admission inflammatory tumor the size of a fist above Poupart's ligament, hard, continuing into the pelvis and to be felt from the rectum; pain on pressure. Incision vented large masses of disintegrated granulation-tissue and pus with feculent odor. Counter-opening above pelvis on dorsum. At first little, subsequently copious discharge making permanent bath necessary. Subsequently discharge continued. Hectic fever set in. Symptoms of chronic lung affection. Death five months after admission. Post-mortem examination revealed a large abscess reaching from the right iliac bone to the liver, into which the intestine had perforated 4 cm. above the cæcum. The pus contained actinomyces germs.

VII. Man, æt. 35, had had jaundice during the summer of 1883, was attacked with symptoms of perityphlitis, October, 1884. December: formation of abscess above posterior superior spine of ileum, which, opened in January, 1885, vented 1½ litres brown offensive pus. February: formation of another abscess near anterior superior spine. venting mostly bloody pulpy matter. May: operation for tumor

which had gradually formed on the os ileum. Incision in the inguinal region disclosed a large cavity on the inside of the ileum approximate to the peritoneum, which communicated with the tumor on the outer side. *Fistulæ* laid open, part of pelvic wall taken away; glands extirpated; drainage; iodoform-gauze tampons. The pus contained *actinomyces fungus*. Soon another abscess opened under Poupart's ligament. June: erysipelas of wound. July: hectic fever; the right lower extremity gradually assumed a position as in the first stage of coxitis. Caries of hip-joint could be diagnosed by probing from anterior fistula. Resection of head of femur. Bad condition of wound treated by continuous bath; gradual decline of patient's strength through diarrhœa and hectic fever. August 15: sudden accession of universal acute peritonitis. Death.

Post-mortem examination revealed the cæcum adherent to the iliac bone; a large abscess reaching to the tuber ischiî, connecting with the hip-joint, with the resection-wound and with a fistula reaching to the sartorius muscle.

VIII. Man, æt. 56, had abdominal colics with vomiting, in the spring of 1882, in three successive attacks. Autumn, 1883, a tumor developed under similar symptoms, gradually increasing in size and situated midway between the umbilicus and the right anterior superior spine. Aspiration having disclosed pus, incision was made, the abscess containing granulation-tissue and pus, curetted; iodoform dressings applied. Wound healed in three weeks. Patient dismissed. Pain said to be again recurring on last accounts. December, 1885.

The first cases tend to corroborate the statements that actinomycosis of the lower jaw is a curable affection, while the interesting disclosures by the microscope of the presence of *actinomyces* germs in carious teeth throw some further light on the manner in which the fungus invades the body. In this connection a case of Murphy, of Chicago, is also cited. In other cases, however, the author admits that our knowledge of the exact mode of entrance of the germ into the body is altogether hypothetical. The fifth case seems to make it probable that the germ may enter through ulcerations of the skin, and also proves that the disease is curable as long as the foci can be reached with our surgical instruments.

The latter cases are classed by the author among abdominal and not with intestinal actinomycoses. He calls attention to the fact that the germs alone do not cause septic symptoms, unless other bacteria, as those from the alimentary canal, accompanying them. He points out the protracted course of the disease as shown in the last two cases, and the pathognomonic anatomical symptoms; the small amount of pus, the tortuous forked fistulæ, the callous thickened walls lining the seat of the affection, and the presence of the small yellow kernels in the pus and in the fungus granulations.

Amyloid degeneration of the internal organs frequently accompanies the disease, as in the two cases before the last.

Operative interference is of little avail in most cases of abdominal mycosis, and cannot well be extended beyond incision and scraping-out of the foci. It is of great importance, however, to keep out septic infections by means of antiseptic dressings, and if these are not sufficient, permanent baths or irrigations are of good service.

In conclusion the author, from a clinical point of view, refutes the opinion advanced by Poleck, that the actinomyces-germs are identical with merulius-fungus.—*Deutsch. Zeitschr. f. Chir.* Bd. 23. Hft. 5 and 6, June, 1886.

W. W. VAN ARSDALE (New York).

II. Troubles Consecutive to Thyroidectomy. By JACQUES L. REVERDIN (Geneva). As a result of the observation of eleven cases of his own with a study of the literature of the subject, the writer concludes: 1. The troubles consecutive to thyroidectomy in the human species constitute the same ensemble of symptoms as myxœdema or *cachexie pachydermique*. 2. Total extirpation of the thyroid body is not invariably followed by myxœdema in the adult. 3. Surgical myxœdema is, unlike medical myxœdema, susceptible of amelioration, perhaps even of cure. 4. In cases of amelioration, small tumors, probably developed in aberrant lobules of the gland, are observed sometimes long after the extirpation; but amelioration may manifest itself without these conditions.—*French Congress of Surgery, Revue de Chirurgie*, November, 1886.

**III. Case of Sudden Death from the Introduction of an Aspirator Needle into a Hepatic Abscess.** By J. C. REEVE, M. D. (Dayton, Ohio). The patient was enfeebled by an illness of six weeks duration and, a diagnosis of hepatic abscess having been made, an aspirator needle was thrust into the liver; the patient immediately went into collapse and, within a minute and a half from the puncture of the needle, life was extinct. Autopsy revealed no lesion other than the abscess of the liver, and the author thinks death was evidently due to inhibition of the heart's action, the impulse being transmitted from the puncture, and is convinced that (1) under full anæsthesia this man would not have died at the time and in the manner he did; (2) under partial anæsthesia, death would have occurred as it did, and would have contributed to swell the list of casualties from anæsthetics; the mode of death is entirely similar to those which have occurred from the extraction of teeth under chloroform, when the movements of the patient, etc. showed that anæsthesia was not profound.—*Med. News*, January 1, 1887.

#### OPERATIVE SURGERY.

**I. Improved Procedure for Inter-Scapulo-Thoracic Amputation of the Upper Extremity.** By PAUL BERGER (Paris). The complete ablation of the upper extremity with the scapula has recently been performed a considerable number of times; the author has collected forty-eight cases with 80 % of success. The procedure which he proposes is the result not only of cadaveric studies, but also of an analysis of all known cases; it is a synthesis of the best methods that have been proposed. It is an amputation by two flaps, one antero-inferior or pectoro-axillary and the other postero-superior or cervico-scapular, in two successive stages which are executed, the former in two steps, the latter in three.

The object of the first stage is preliminary hæmostasis; it begins with section of the clavicle followed by resection of the middle part of that bone (first step) and ends with isolation and division between two ligatures of the subclavian vessels (second step).

The second stage begins with the formation and deep dissection of